BEFORE THE DEPARTMENT OF LABOR AND INDUSTRY
STATE OF MONTANA

In the matter of the amendment of ARM 24.29.207, 24.29.1404, 24.29.1426, 24.29.1504, 24.29.1521, 24.29.1532, 24.29.1536, 24.29.1541, 24.29.1551, 24.29.1561, 24.29.1566, 24.29.1572, 24.29.1573, 24.29.1582, 24.29.1583, and 24.29.1584, and the adoption of NEW RULES I through VIII, related to the workers' compensation medical fee schedule for nonfacilities, the workers' compensation medical treatment and utilization guidelines for occupational therapists, physical therapists, and chiropractors, and other matters related to workers' compensation claims	)))))))))))))))))))	NOTICE OF AMENDMENT AND ADOPTION

TO: All Concerned Persons

1. On September 6, 2007, the department published MAR Notice No. 24-29-225 regarding the public hearing on the proposed amendment and adoption of the above-stated rules at page 1265 of the 2007 Montana Administrative Register, issue no. 17.

2. On September 28, 2007, a public hearing was held in Helena concerning the proposed rules at which oral and written comments were received. Additional comments were received prior to the closing date of October 5, 2007.

3. The department has thoroughly considered the comments and testimony received on the proposed amendments and new rules. The following is a summary of the comments received, along with the department's response to those comments:

Comment 1: Regarding ARM 24.29.207, the Montana State Fund requested the department properly coordinate one of the amendments to this rule with the insurance commissioner's rules. Specifically, the State Fund requested the department modify (3) to add the words "or Plan 3" to clarify that decisions made by the classification review committee on employment classifications in contested cases apply to the State Fund. The State Fund believes this modification is necessitated by the provisions of 33-16-1011 and 33-16-1012, MCA, and by ARM 6.6.8201 to 6.6.8206.

Response 1: The department agrees this clarification is appropriate and has amended the rule accordingly.

Comment 2: The Montana State Fund noticed an error in the proposed amendments to ARM 24.29.1566 in that the catchphrase applies the rule through December 31, 2007, but the amendment to the text applies the rule through December 30, 2007.

Response 2: The department agrees there was a typographic error in the text of the rule and has amended the rule accordingly.

Comment 3: Regarding New Rule III, the nonfacility fee schedule, the State Fund commented that in (1), the term "medical service" is used prior to the term "provider". The State Fund recommends deleting "medical service" before "provider" so as to not confuse the definition of "provider" in proposed Rule 24.29.1504(12). The State Fund also notes the term "medical services" is used in 39-71-704, MCA. The State Fund recommends modifying the sentence to read as follows: "(1) The department adopts the fee schedule provided by this rule to determine the reimbursement amounts for medical services provided by an individual ~~medical service~~ provider at a nonfacility or facility furnished on or after January 1, 2008."

Response 3: The department agrees and has amended the rule accordingly.

Comment 4: The State Fund requests that the new rules be numbered to be included in subchapter 15 of the department's rules so that the definitions in 24.29.1504 will apply to the new rules, as the use of the definitions is currently applicable to subchapter 15.

Response 4: As this was the intent of the department, the department agrees and is numbering New Rules II through VII to be included in ARM Title 24, chapter 29, subchapter 15. The department believes that New Rule I is most logically numbered as part of subchapter 14, however, following a similar rule related to hospital services.

Comment 5: The State Fund requests that in New Rule III, (6) be amended to clarify the status of "nonlicensed providers". The State Fund believes that not using the term "provider" in addressing nonlicensed services would avoid confusion. In addition, the State Fund requests language be added to indicate that an insurer's prior approval is required for payment for nonlicensed services. The State Fund proposes the following amendment: "(6) Each provider is to limit services to those which can be performed within the limits and restriction of the provider's professional licensure. ~~For nonlicensed providers,~~ If an individual provides non licensed medical services, and the services are approved by the insurer, the insurer is not required to reimburse above the related CPT codes for appropriate services."

Response 5: While the department understands the State Funds' desire for more clarity, the department believes that the requested changes are outside the scope of the proposed rule notice because notice to the public was not given regarding these suggested changes. Accordingly, the department concludes that it would not be

appropriate to make the requested change at this time. Further, the department notes that the definition of provider does not require licensure. The department will consider clarifying this issue in the future.

Comment 6: The Montana Chapter of the American Physical Therapy Association requested clarification as to why New Rule III(6) addresses reimbursement to nonlicensed providers under the RBRVS.

Response 6: As an example, currently in Montana, massage therapists are not licensed by the state. It is the department's understanding that some treating physicians reasonably prescribe massage as an appropriate therapy for treatment of certain conditions. Therefore the department believes that the rule is necessary to indicate the reimbursement rates for those providers.

Comment 7: The State Fund and the Montana Chapter of the American Physical Therapy Association requested the department clarify that under New Rule III(8), which provides for the new Montana unique code MT001, providers will be reimbursed for conferences with vocational rehabilitation counselors.

Response 7: The department agrees that providers should be reimbursed by insurers for activities required by vocational rehabilitation counselors. However, the department does not believe clarification in the rule is required because it considers vocational rehabilitation counselors to be payor representatives and as such are already included in the rule. Accordingly, any face to face conferences, nonphysician conferences, or completion of a job description or job analysis form requested by a vocational rehabilitation counselor would be reimbursed under MT001. This response shall serve as the clarification requested.

Comment 8: The Montana Chapter of the American Physical Therapy Association commented that the department should add a requirement that insurers shall make payments to providers within 30 days, similar to the requirement that insurers pay hospitals within 30 days as provided by ARM 24.29.1426 and New Rule I.

Response 8: The department agrees that insurers should make timely payments to providers, as this is required by the reasonableness standard in 39-71-704, MCA. However, a specific administrative rule to that effect is outside the scope of this rules proposal and therefore cannot be addressed in this notice. The department will consider proposing such a requirement in the future.

Comment 9: Numerous commentors expressed support for the proposed amendments and new rules and indicated general support for switching to the RBRVS system. In addition, the State Fund and the Montana Chapter of the American Physical Therapy Association expressed support for using MT001 to clarify payment for payor conferences. Specifically, the Montana Chapter of the American Physical Therapy Association noted that this code allows for the additional administrative costs of handling a workers' compensation claim.

Response 9: The department acknowledges the comments.

Comment 10: Regarding New Rule V, the chiropractic fee schedule, and New Rule VII, the occupational and physical therapy fee schedule, the State Fund requested that code 99070 be deleted from the proposed rules and replaced with instructions to bill supplies using the appropriate HCPCS code for these items per ARM 24.29.1521. The State Fund noted that report code 99070 is a by report code for supplies and materials beyond the normal office visit.

Response 10: The department agrees in part and has amended the rule accordingly. The department believes that changing from code 99070 to the HCPCS codes does not constitute a substantive change. The department notes however that chiropractors and occupational and physical therapists do not bill under ARM 24.29.1521 or New Rule II. Rather, they are restricted to billing under the codes allowed by ARM 24.29.1572, 24.29.1582, 24.29.1584, New Rule V and New Rule VII. Therefore, the amendments add the HCPCS requirement to New Rules V and VII. Similarly, the department notes that HCPCS codes also provide reimbursement amounts for any medication used in conjunction with iontophoresis. Therefore, this clarification is made within New Rule VII, rather than in the prescription drug fee schedule.

4. The department has amended the following rules as proposed, but with the following changes from the original proposal, new matter underlined, deleted matter interlined:

24.29.207 CONTESTED CASES (1) and (2) remain as proposed.

(3) A contested case concerning employment classifications assigned to an employer by a Plan 2 or Plan 3 insurer is administered by the classification review committee in accordance with 33-16-1012, MCA.

(4) remains as proposed.

AUTH: 2-4-201, 39-71-203, MCA
IMP: Title 2, chapter 4, part 6, 33-16-1012, 39-71-204, 39-71-415, 39-71-704, 39-71-2401, 39-71-2905, MCA

24.29.1566 PHYSICIAN FEES -- ANESTHESIA SPECIALTY AREA FOR SERVICES PROVIDED FROM APRIL 1, 1993, THROUGH DECEMBER 31, 2007

(1) For services provided from April 1, 1993, through December ~~30~~ 31, 2007, except as otherwise provided by this rule, fees for the anesthesia medical specialty area are payable according to the values listed in Relative Values for Physicians. Special unit value rules listed in (4) and (5) are established for anesthesia. Those special unit value rules supersede the corresponding unit values listed in Relative Values for Physicians, and apply to all providers. A physician who furnishes other medical services in addition to anesthesia must use the fee schedule that applies to the services rendered.

(2) through (5) remain as proposed.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

5. The following rules have been amended as proposed: 24.29.1404, 24.29.1426, 24.29.1504, 24.29.1521, 24.29.1532, 24.29.1536, 24.29.1541, 24.29.1551, 24.29.1561, 24.29.1572, 24.29.1573, 24.29.1582, 24.29.1583, and 24.29.1584.

6. The department has adopted the following rules as proposed:

NEW RULE I (24.29.1427) HOSPITAL SERVICE RULES FOR CLAIMS ARISING ON OR AFTER JANUARY 1, 2008

NEW RULE II (24.29.1522) MEDICAL EQUIPMENT AND SUPPLIES FOR DATES OF SERVICE ON OR AFTER JANUARY 1, 2008

NEW RULE IV (24.29.1538) CONVERSION FACTORS FOR SERVICES PROVIDED ON OR AFTER JANUARY 1, 2008 – METHODOLOGY

NEW RULE VI (24.29.1575) CHIROPRACTIC -- PRIOR AUTHORIZATION AND BILLING LIMITATIONS FOR SERVICES PROVIDED ON OR AFTER JANUARY 1, 2008

NEW RULE VIII (24.29.1586) OCCUPATIONAL AND PHYSICAL THERAPISTS -- PRIOR AUTHORIZATION AND BILLING LIMITATIONS FOR SERVICES PROVIDED ON OR AFTER JANUARY 1, 2008

7. The department has adopted the following rules as proposed, but with the following changes from the original proposal, new matter underlined, deleted matter interlined:

NEW RULE III (24.29.1533) NONFACILITY FEE SCHEDULE FOR SERVICES PROVIDED ON OR AFTER JANUARY 1, 2008 (1) The department adopts the fee schedule provided by this rule to determine the reimbursement amounts for medical services provided by an individual ~~medical service~~ provider at a nonfacility or facility furnished on or after January 1, 2008. An insurer is not obligated to pay more than the fee provided by the fee schedule for a service provided within the state of Montana. The fee schedule is comprised of the following elements:

(a) through (12) remain as proposed.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

NEW RULE V (24.29.1574) CHIROPRACTIC FEE SCHEDULE FOR SERVICES PROVIDED ON OR AFTER JANUARY 1, 2008 (1) and (2) remain as proposed.

(3) Only the following codes may be billed for chiropractic services:

(a) remains as proposed.

(b) special services, procedures, and report codes ~~99070,~~ 99080, ~~and~~ MT001, and HCPCS codes for supplies and materials. Code MT001 is described in ARM 24.29.1533. A separate written report must be submitted describing the service provided when billing for the codes identified in this subsection;

(c) through (7) remain as proposed.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

NEW RULE VII (24.29.1585) OCCUPATIONAL AND PHYSICAL THERAPY FEE SCHEDULE FOR SERVICES PROVIDED ON OR AFTER JANUARY 1, 2008

(1) and (2) remain as proposed.

(3) Only the following codes found in the nonfacility fee schedule may be billed for services provided by occupational therapists and physical therapists:

(a) remains as proposed.

(b) special services, procedures, and report codes ~~99070,~~ 99080, ~~and~~ MT001, and HCPCS codes for supplies and materials. Code MT001 is described in ARM 24.29.1533. A separate written report must be submitted describing the service provided when billing for the codes identified in this subsection.

(4) remains as proposed.

(5) When billing code 97033 (iontophoresis), medication charges and electrode charges must each be billed separately for each visit using ~~code 99070~~ HCPCS codes.

(6) and (7) remain as proposed.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

/s/ MARK CADWALLADER
Mark Cadwallader
Alternate Rule Reviewer

/s/ KEITH KELLY
Keith Kelly, Commissioner
DEPARTMENT OF LABOR AND INDUSTRY

Certified to the Secretary of State October 15, 2007